Diabetic Testing, Insulin Pump, and Insulin Pump Supplies Detailed Written Order

AIM PLUS MEDICAL SUPPLIES

Please fax form with Physician's signature to 1-866-496-7054

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Primary Phone: _____ Alternate Phone: _____

Address: _____ City/State/Zip:_____

Primary Insurance: _____ ID# _____

Secondary Insurance: _____ ID# _____

Contact person if other than patient: _____

REQUIRED INFORMATION FOR ALL PATIENTS

Date of last office visit: _____ Duration of Need (12 months unless other wise noted): _____

Type 1- IDDM Insulin Dependent	Type 2- Check One Pills, Diet, and/or Insulin Treated
___ E10.9 (250.01)	___ E11.9 (250.00)
___ E10.65 (250.03)	___ E11.65 (250.02)
___ Other _____ (specific)	___ Other _____ (specific)

PLEASE COMPLETE THIS SECTION IN FULL.

Using insulin shots to control? ___ Yes ___ No Number of injections a day:____ Testing frequency: _____

Currently using a pump? ___Yes ___No Date when patient started using the pump:_____ A1C: _____

___ Glucose Test Strips

Product Name:_____

___ Lancets

Product Name: _____

___ Lancing Device PRN

___ KetoStix

___ Alcohol Swabs

___ Meter Battery PRN

___ Control Solution PRN

___ Meter PRN

___ Transparent Tape

___ Prep Wipes

___ Adhesive Remover

___ Other _____

___ Infusion sets

___ Reservoirs

___ *Omnipod insulin pump (PDM)

___ *Omnipod Pods

*Additional documentation may be required.

___ Other _____

My signature below denotes to the best of my knowledge the patient/caregiver is able to follow instructions for contolling diabetes and is able to use the ordered items which are designed for home use. The patient/caregiver has successfully completed training or is scheduled to begin training in the use of supplies or equipment ordered. I am a physician who manages patients with diabetes and/or insulin pump therapy and who works closely with a team including nurses, diabetes instructors and dieticians who are knowlegeable in the use of subcutaneous insulin infusion therapy.

Physician Staff Contact: _____

Physician Name (print) _____ NPI # _____

Physician Signature _____ Date _____

Physician Phone # _____ Fax # _____

6521 Hwy 69 S, Suite N, Tuscaloosa, AL 35405 Phone 866-919-1246 Fax 866-496-7054